District of Columbia

Coordinated Assessment and Housing Placement (CAHP) Policy and Procedures for Individuals

1. Overview

Coordinated Entry, referred to locally as Coordinated Assessment and Housing Placement for Individuals, or I-CAHP, represents standardized access and assessment for all individuals experiencing homelessness within the District of Columbia, whether that homelessness includes any combination of emergency shelter, transitional housing or locations outdoors not meant for human habitation. Individuals receive referrals for housing (permanent supportive housing, targeted affordable housing, rapid rehousing, transitional housing, and other housing options) based on acuity of service needs (including medical vulnerability, mental health needs, substance use issues and other risk factors) and length of homelessness. The CAHP system also facilitates connections to services and temporary housing to meet immediate needs, in addition to helping individuals explore housing options outside of the CAHP system when possible.

The CAHP process for adult single individuals intentionally utilizes a de-centralized "no wrong door" approach, while doing so through a standardized process from initial engagement to successful housing placement. This prevents what otherwise often feels like a confusing and overwhelming maze for individuals experiencing homelessness as they try to determine who to talk to, how to get there, and where to begin. Instead, I-CAHP establishes a system where housing placement is not a matter of talking to the right case manager, at the right agency, at the right time. This CAHP system ensures individuals are connected to housing through a coordinated yet accessible process, meets each individual's needs to obtain and maintain housing, and includes the real time data critical for demonstrating unmet needs and advocating to develop and integrate new housing inventory within this process.

The District of Columbia is committed to the continuous improvement of the Coordinated Assessment and Housing Placement (CAHP) as a key strategy to ensure homelessness in the District is rare, brief and non-recurring according to the goals of the local strategic plan to end homelessness, Homeward DC.

The Community Partnership for the Prevention of Homelessness (TCP) serves as the DC CoC CAHP System Administrator, HMIS Lead and CoC Collaborative Applicant.

2. Assessment Tool

Overview

More than 115 agencies representing more than 800 staff have been trained on the common assessment tool for the District of Columbia's Coordinated Assessment and Housing Placement system for single individuals. Providers utilize the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) as the common assessment, currently utilized by more than 130 communities worldwide, to screen any single individual experiencing homelessness. (Individuals not identifying themselves as homeless -- residing on the streets, place not meant for habitation, hotel/motel paid for by charitable organizations or federal, state or local government, in shelter or transitional housing -- and families do not receive an assessment through this process). The assessment takes approximately 10 minutes to administer by any provider who has been trained on the tool via a two hour training conducted by The Community Partnership (TCP) in their role as CAHP System Administrator. This training will include a step by step process for how to record the VI-SPDAT results within the Homeless Management Information System (HMIS).

Accessing Training:

Trainings on both the VI-SPDAT and Full SPDAT are offered monthly. Registrations links are distributed via cahp@community-partnership.org . The VI-SPDAT training includes an overview of the Coordinated Assessment and Housing Placement system, use of the Release of Information (ROI), VI-SPDAT assessment and how to record its results within the Homeless Management Information System (HMIS). In addition, it covers SkanPoint, a module used in HMIS to record service and outreach engagements for clients, an essential function to the development of the By Name List.

Additional trainings to address data quality concerns and continuous quality improvement are held on an as needed basis, including how to record and monitor open assignments and how to record re-experiences of homelessness. To retain HMIS licensure, all staff that have completed training must properly record assessment results within the HMIS and actively utilize the system. Failure to do so, or inactivity within the HMIS of over six months will require an additional "refresher training" prior to re-licensure.

Staff that attend any I-CAHP match meetings or additional meetings in which Protected Health Class Information covered under the HIPAA-compliant Release of Information used in the CAHP process is discussed must have attended the training outlined above and have signed a User License Agreement prior to attendance.

Please note that additional training is required prior to certification to conduct the SPDAT, or "full SPDAT" assessment, involving a one-day training from The Community Partnership (TCP).

3. Conducting Assessments

Messaging:

All assessors who are trained for the VI-SPDAT tool receive standardized messaging so that staff communicate the assessment process and its results clearly and consistently across the community. This ensures both that the benefits to participating in a survey are described clearly in order to encourage people to participate, but is equally important to make sure that individuals understand that participating does not guarantee (and may not result in) housing. It is also important that individuals receive a clear understanding of where their information will be shared. Assessors are provided more detail in each training and including additional messaging documents for both clients and housing providers. See Appendix D "Recommended VI-SPDAT Assessment Script for Assessors".

All suggested messaging must contain the following components:

- Name of the assessor and their agency
- Purpose of the VI-SPDAT being completed
- 10 minute duration of the assessment
- Only "yes," "no" or one-word answers are being sought
- Where the information is stored within the Homeless Management Information System
- Assessment information will be shared with providers conducting assessments in D.C. and the housing providers connected to the CAHP system so that the individual does not need to complete the assessment multiple times, that housing providers can identify people to target for housing resources as they come available, and for planning purposes.

If an individual agrees to participate in the CAHP process described in its messaging, then they are asked to sign the release of information before proceeding with the assessment.

After completing the assessment, there is recommended messaging and a "VI-SPDAT – What's Next" handout that can be shared with the individual. See Appendices F and G for the recommendation messaging and handout.

Release of Information:

The Vulnerability Index/Service Prioritization Decision Assistance Tool (VI-SPDAT) pre-screen assessment requires the completion of the Release of Information (ROI). The same ROI is utilized by all providers to input all assessments within the HMIS. It is informed by the national model learned of during the 100k homes campaign with D.C. specific language to share the results from the VI-SPDAT pre-screen assessment and full SPDAT. It also includes language pertaining to the District of Columbia Mental Health Information Act. It was approved by the Veterans Affairs Central Office, Community Resource and Referral Center, and team leaders from the CAHP System upon the launch of the CAHP System in 2014.

Refusals of Assessment:

Individuals who do not sign the release of information do not complete the assessment. For limited instances when individuals refuse specific questions throughout the assessment process, the assessor may request permission to ask additional questions in order to utilize their conversation with the individual, surveyor observation, documentation and information from other professionals in order to provide responses. When staff encounter individuals who do not provide a response to any of the first questions, they should stop and acknowledge that the assessment will not provide useful information if the individual receiving assessment does

not want to participate. Staff should utilize continued progressive engagement and rapport building with these individuals until they are willing to be assessed.

Individuals who are not able to complete either a VI-SPDAT or full SPDAT may be referred to the Housing Assignment Review Panel or "case conferencing" described on page 11.

Coordination with Victim Service Providers:
Roughly seven percent of single idividuals report fleeing from domestic violence as the cause of their homelessness. Victim service providers play an integral part in the District's homelessness response system by providing shelter, transitional housing, advocacy, and supportive services for survivors forced to leave their homes. For this reason, HUD encourages CoCs to work with victim service providers, see guidance here[1], within the CoC's geographical area to establish client-driven, trauma-informed and culturally-relevant screening tools, as well as referral policies and procedures to ensure that the coordinated entry process addresses the physical and emotional safety, and privacy and confidentiality needs of participants.

For clients who indicate fleeing domestic violence on the VI-SPDAT or over the course of conversation, it is important to give that client options that will fit his/her unique needs. Providers are encouraged to develop relationships with and make warm referrals to victim service providers – see a full list of victim service providers here[2]. Providers can also call the DC Victim Hotline[3] at 1-844-4HELPDC. This resource connects survivors to a host of supportive services, including domestic violence specific emergency shelter options.

Completion of the Assessment Process:

Upon completion of the VI-SPDAT, the Assessor may provide information regarding the recommended housing intervention (Permanent Supportive Housing, Rapid Rehousing or One-Time Assistance), however should ensure that individuals understand that this assessment is not a guarantee of housing or of the specific resource recommended through the completion of the VI-SPDAT. The assessor should ask if the individual is currently working with a provider towards one of those forms of housing assistance and, if so, the individual receiving assessment should be encouraged to continue to engage with their existing case management supports. If not, staff can provide a brief description of the resources currently available within the community and ask if the individual is interested in that form of housing assistance. These resources change frequently, and are regularly updated at www.coordinatedentry.com/forms and www.coordinatedentry.com/help, and can be provided to the individual being assessed.

Assessors should emphasize the importance of having reliable and comprehensive information regarding the best time and place to contact the individual. Staff should collect information on whereabouts across a 24 hour period, beginning with where they wake up until they bed down at night, with notations for days when location patterns changed, and record that information within the VI-SPDAT. This includes where meals are obtained, transportation methods and times to and from meal and shelter providers, cross streets of services received, outside agency names and staff with whom they engage, etc.

Assessors may emphasize that while completion of the assessment does not make them now the individual's case manager, it remains critically important that the assessor possesses the most reliable methods possible for locating the individual being assessed, especially if that includes an outside agency or staff attempting to contact the individual at a later date.

[1] https://www.hudexchange.info/resources/documents/Coordinated-Entry-and-Victim-Service-Providers-FAQs.pdf
[2] https://www.dccadv.org/index.php?pid=38
[3] https://dcvictim.org/

To this end, the following the recommended messaging for each of the housing recommendations that result from the completion of the VI-SPDAT are included in Appendix D "Recommended VI-SPDAT Assessment Script for Assessors – Post VI-SPDAT Discussion".

Anonymous Clients & Assessments:

If there is a concern for anonymity, particularly with domestic violence and victim services providers, there are several ways for clients to remain connected and involved in the coordinated entry system. For example, if the client is working with a particular service agency, that agency can use their agency/program name in lieu of the client's name for safety purposes in the HMIS. If there is a reason this method can not be used, service providers may submit completed assessments to CAHP staff who can add the anonymous client information to the By Name List used for each matching meeting and maintain internal tracking. Finally, service providers are permitted to case conference (see page 11) individuals who may not be able to take an assessment or enter any information into HMIS. The outcome of this case conference discussion is based on the availability and appropriateness of resources and the service provider most familiar with the case is expected to be present to share relevant information.

Full SPDAT Process:

While the VI-SPDAT is a pre-screen or triage tool that looks to confirm or deny the presence of more acute issues or vulnerabilities, the SPDAT (or "full SPDAT") is an assessment tools looking at the depth or nuances of an issue and the degree to which housing may be impacted.

To provide a safety net for instances where the VI-SPDAT does not seem to accurately reflect their service needs and medical vulnerability, individuals would be recommended for full SPDAT assessment. The primary reason for recommending a SPDAT is when the individual being assessed under or over-reports what the Assessor observes or knows through outside observation. Once the SPDAT has been recorded within HMIS, the SPDAT score may be considered along with VI- SPDAT when prioritizing outreach assignments and/or housing placement according to the local prioritization criteria as detailed in Appendix B. Those who have received a full SPDAT assessment will periodically be reviewed through the case conferencing and housing match processes.

In instances where individuals have both a full SPDAT and VI-SPDAT assessment, when appropriate, referral for housing placement will prioritize the full SPDAT and not solely the VI-SPDAT score.

Individuals who are not able to complete either a VI-SPDAT or Full SPDAT may be reviewed via the Case Conferencing process held during the I-CAHP match meetings.

4. Outreach and Engagement

Outreach and engagement is an important part of the CAHP System and involves many functions: building trusting relationships with individuals experiencing homelessness, working to reach all individuals experiencing homelessness in shelters and in unsheltered environments, helping individuals stay connected to the CAHP System and facilitating housing matches.

Outreach and engagement is done by may CAHP System providers – street outreach teams, shelter providers, providers and meal and drop-in center programs, DHS staff, etc.

A. Assessments

In addition to the standard process for assessments across shelters, service centers, street outreach, and other CAHP access points, there are times when outreach and engagement providers are asked to help with targeted assessment efforts where there is inadequate assessment coverage in parts of the system (for example, certain shelters) or with certain populations (for example, women or veterans).

Outreach and engagement providers may also be asked to help with targeted assessments as part of facilitating the housing match facilitation process. For example, an outreach and engagement provider may be asked do further outreach, engagement, gather further information, and/or a full SPDAT for individuals discussed in case conferencing or who are recommended for a match through the By Name List.

B. Establishing relationships, connection to services, and document collection

As outreach and engagement providers, important tasks include:

- establishing trusting relationships
- helping connect individuals to services and temporary housing to meet immediate needs, in addition to helping individuals explore housing options outside the CAHP system
- assisting with collecting the documents needed for the housing process and other goals

In addition to their general work with everyone, outreach and engagement providers are asked to prioritize these activities with individuals who are likely to be matched to housing through CAHP. The housing match process is faster and more effective when individuals are already located, engaged, and have their necessary documents.

C. Housing Match Facilitation

In some circumstances, outreach and engagement providers may also be asked to help facilitate the housing match process for individuals who are already matched to a housing provider, when the housing provider is having difficulty moving through the housing process with an individual for some reason. Examples of helping facilitate the housing match process include:

- Locating individuals and facilitating introductions and coordination with housing providers
- Engaging individuals and encouraging them to participate in the housing process

5. Housing Match & Case Conferencing Process

Housing Match Prioritization

The District of Columbia has developed a local prioritization criteria through a community process, according to the core requirements set forth by the U.S. Department of Housing and Urban Development (HUD). These criteria are informed by data and trends seen in the local community and include assessment score and information about factors such as self-reported length of time homeless, length of stay in shelter as well as health and wellness considerations. The VI-SPDAT and SPDAT will be the ONLY tools used to formally assess individuals at the point of entry. The assessment scores are used to triage individuals into the appropriate category of intervention. The prioritization criteria is reviewed and updated, at minimum, on an annual basis.

These criteria are slightly different for each resource type available: permanent supportive housing, targeted affordable housing, rapid rehousing and transitional housing programs. Detailed descriptions of the prioritization criteria for each resource is included in Appendix B.

It is important to note that emergency and low barrier shelter placements are not subject to prioritization criteria as they must be available for immediate crisis response and operate with the lowest barriers to entry possible.

Information used in the prioritization criteria for all housing resources, in accordance with the D.C. Human Rights Act of 1977, as amended, D.C. Official Code Section 2-1401.01 et seq., (Act) the District of Columbia does not discriminate on the basis of actual or perceived race, color, sex (Gender or sexual harassment), national origin, religion,, sex, age, marital status, personal appearance, sexual orientation, gender expression or identity, familial status, family responsibilities, matriculation, political affiliation, genetic information, disability, source of income, place of residence or business. The D.C. Human Rights Act of 1977, Section 2-1402.31(a) of the D.C. Code, prohibits acts performed wholly or partially for a discriminatory reason: "To deny, directly or indirectly, any person the full and equal enjoyment of the goods, services, facilities, privileges, advantages, and accommodations of any place of public accommodation…"

The prioritization criteria is the framework for housing programs that operate within each designated type. However, housing programs may maintain additional target populations according to their receipt of local and/or federal funds. Clients, consumers or participants who wish to file a non-discrimination complaint can do so in the following ways:

- Clients, consumers or participants who wish to file a non-discrimination complaint can do so by:
    - Calling The Community Partnership Complaint Hotline: 1 (877) 341-3702.
    - Sending an email to feedback@community-partnership.org **OR**
    - Calling TCP's admin number at (202) 543-5298 (Mon-Fri 9a -5p);

- Any individual can submit a suggestion for improvement or a complaint related to a DHS program or service to the DHS Office of Program Review, Monitoring and Investigation (OPRMI) by:
    - Completing and submitting the online Suggestions and Complaint Form;
    - Emailing a description of the suggestion or complaint to OPRMI@dc.gov;
    - Faxing a description of the suggestion or complaint to (202) 671-4409;
    - Calling the Complaint Hotline at (202) 673-4464; or
    - Mailing or delivering a report to:
      DHS Office of Program Review, Monitoring and Investigation (OPMRI)
      64 New York Avenue, NE,6th Floor,
      Washington, DC 20002

- Complaints of possible violations of this law may be filed with:
    - Government of the District of Columbia Office of Human Rights
    - 441 4th Street, N.W., 570N Washington, D.C. 20001
    - Telephone (202) 727-4559 Fax (202) 727-9589 www.ohr.dc.gov

I- CAHP Housing Match Meetings

The Singles CAHP Coordinator hosts twice-monthly I-CAHP matching meetings, attended by a community team comprised of assessors, service providers, outreach workers, points of contact, and housing providers. The main purpose of this meeting is primarily to facilitate referrals to Permanent Supportive Housing (PSH) and Targeted Affordable Housing (TAH). However, the I-CAHP matching meetings continue to expand in

order to identify and facilitate referrals or matches to Rapid Rehousing (RRH) and Transitional Housing (TH) resources. Vacancies are filled according to the prioritization criteria and use of the By Name List or the Case Conferencing Tracking Sheet (see Appendix A: Glossary of Terms).

Both Veterans and non-Veterans will be assigned or matched to housing when they are first identified as potential candidates for a specific program or resource according to the local prioritization criteria for that resource type, with the understanding that further eligibility determinations may still need to be made. Members of the community team are expected to provide information regarding each client known to them as they are identified through the review of the By Name List, so that everyone understands the viability of the match (including knowledge of service needs, ability to find the individual and likelihood of client accepting housing offer) before it is made and can confirm the appropriateness of moving forward.

Veterans CAHP Case Conferencing/Matching Meetings

Veterans PSH Case Conferencing Meetings

The Veterans CAHP Coordinator hosts weekly Veterans CAHP meetings, attended by a community team comprised of assessors, service providers, outreach workers, housing navigators, and housing providers. The main purpose of this meeting is to facilitate referrals to Permanent Supportive Housing (PSH). Vacancies will either be filled using the Veteran By Name List or the Case Conferencing Tracking Sheet (see Appendix A: Glossary of Terms).

Veterans will be assigned or matched to housing when they are first identified as potential candidates for a specific program or resource, with the understanding that further eligibility determinations may still need to be made. Members of the community team are expected to provide information regarding each client known to them as they are identified through the review of the By Name List, so that everyone understands the viability of the match before it is made and can confirm the appropriateness of moving forward.

Focus on Subpopulations of Veterans

Although, the focus of the Veteran Case Conferencing meeting is to facilitate matches to permanent housing, the Veteran's Community Team is also committed to streamlining care coordination for various subsets of Veterans. These subpopulation focuses include making matches to outreach service providers, SSVF, and GPD/VA Contract beds, as well as analyzing Veterans who may be newly experiencing or re-experiencing homelessness.

Case Conferencing Process & Criteria (Veterans and Non-Veterans)

While the By Name Lists remains the primary mechanism used to identify referrals to permanent and other housing options, community members may also case conference a client for possible connection to housing opportunities during the I-CAHP match meetings. The CAHP Community Team, as part of its regular I-CAHP match meetings, will periodically review cases of individuals where an individualized review is needed:

- individuals who are unable or unwilling to complete a VI-SPDAT or SPDAT assessment; or
- Instances where extenuating circumstances may dictate a different housing intervention recommendation than that of the VI-SPDAT or SPDAT assessment.

Case conferencing provides a safety net for individuals where the tool may not accurately reflect the full depth and/or urgency of the situation, not a side door to the process. Individuals who would come up naturally during the matching and prioritization process need not be case conferenced.

Assessors/case managers/Case Conference meeting attendees must demonstrate professional judgment in this process, remaining objective in the reviews of cases. When an individual is matched to housing through case conferencing, this means that a match was not made from the prioritized By Name List, so the standard for a case conferencing match is that the community participants collectively decide that it is more urgent to match the individual being case conferenced than the next person prioritized on the BNL.

Those that repeatedly refer a large percentage of individuals to the review panel may be required to attend additional training and/or explore other measures. The intention of the review panel is to allow for some element of individual attention and conversation in the process, but at the same time maintain a uniform and transparent process.

Case Conference Process

The following outline details the steps taken before, during, and after the case conferencing process.

1. Identify which of the following criteria or exceptions consumers meet in order to be case conferenced (detailed in section below "Case Conference Criteria").
2. Complete and send the case conferencing template to the identified CAHP staff, detailing the reason for case conferencing and additional notes or concerns about the case (i.e. data quality issues, etc.).
3. CAHP staff will identify interim next steps prior to the matching meeting where applicable and ensure case conferencing criteria is met. This may include a review of the HMIS profile(s), profile merges and data clean up, as well as verification of information with the staff who is requesting the case conference. This interim review may result in a recommendation to not case conference the individual if it can be resolved offline.
4. CAHP community participants collectively make decisions during the next available I-CAHP match meeting about the following potential outcomes:
    a) Match if/when a resource is available in conjunction with the By Name List
    b) Next Steps Needed
        i. Update the Full SPDAT;
        ii. Connect to CSA;
        iii. Documentation;
        iv. Other next steps
    c) Match through By Name List according to the identified prioritization criteria.

Case Conference Criteria

Community members may case conference a client for connection to a housing resource if one or more of the following criteria apply:

1. **The individual is scoring for a particular resource, but would not appear on the By Name List that is used to make matches because of constraints regarding date entry or extenuating circumstances.**
    a. Possible outcome(s):

i. The I-CAHP Coordinator and Community Team will troubleshoot data entry related capacity issues.
ii. When these issues cannot be resolved, the client will be added to the Case Conferencing Tracking Sheet.

2. **The individual is re-experiencing homelessness after being housed previously.**
    a. Possible outcome(s):
        i. The case can be considered for an immediate re-connection to a housing resource dependent on factors related to their loss of housing.
3. **The individual was previously matched to a resource, but was unassigned:**
    a. Possible outcome(s):
        i. The case can be considered for an immediate re-connection to a housing resource dependent on factors related to the unassignment.
4. **The individual is scoring for a particular resource and has chronically refused housing assistance, but recently became motivated to accept housing:**
    a. Possible outcome(s):
        i. The case can be considered for an immediate connection to a housing resource.

Individuals who are already housed or matched to a resource, but are determined as needing a higher level of care or "step up", may be addressed on a case by case via the case conferencing process.

The case conferencing review process is person-centric, not program-centric. That is, the end result will not always be connection to a permanent placement, but rather to match a highly vulnerable person to an appropriate housing resource. For example, an individual with extreme medical needs may be case conferenced because he/she is at risk of dying, but if only a housing subsidy is available (without intensive wraparound services), the individual may not be matched to that resource, rather prioritized for an intervention such as targeted affordable housing with other supports or connection with other community resources.

The only guarantee related to the case conferencing process is that the individual will receive a review. Not all cases result in immediate placement. In some instances, the review panel may determine that the initial score and position on the registry is correct given the severity of other cases. In other situations, the review panel may determine that a higher score is warranted, though immediate placement is still not feasible. In still other situations, the review panel may determine that immediate placement is needed to reduce risk of death.

Generally, no more than 5% of placements throughout the fiscal year should be made through the case conferencing review process to ensure that use of the By Name List is the primary matching process.

Additional Case Conferencing Information

In order to be considered for a case conferencing discussion in the Singles CAHP meetings, all Veterans must meet the Veteran PSH Case Conferencing Criteria and must first be case conferenced in the Veterans CAHP case conferencing meetings. The Veteran community team will review the case and come to a consensus regarding whether the client should be added to the Case Conferencing Tracking Sheet for additional discussion or future housing match. All Veterans added to the Veterans Case Conferencing Tracking Sheet will also be added to the Singles Case Conferencing Tracking Sheet.

Matching to PSH with the Veteran By Name List & Case Conferencing Tracking Sheet

As mentioned above, vacancies will either be filled using the Veteran By Name List or the Case Conferencing Tracking Sheet (see Appendix A: Glossary of Terms). Both will be sorted by the Local CAHP Prioritization Criteria for Permanent Supportive Housing (PSH), Shelter Plus Care (S+C) and Dedicated Plus Program (D+) (see Appendix B: Local CAHP Prioritization Criteria).

The community team will simultaneously review Veterans on the By Name List and Case Conferencing Tracking Sheet, flipping back and forth between each list to identify Veterans with the highest VI-SPDAT or Full SPDAT score OR longest length of homelessness (depending on which sort is being applied)

The Veterans CAHP Coordinator and the community team commit to upholding the following principles:

- If the first Veteran on the By Name List has a higher VI-SPDAT or Full SPDAT score OR a longer length of homelessness than the first Veteran on the Case Conferencing Tracking Sheet, the Veteran on the By Name List will be considering for a match to PSH first.
- If the first Veteran on the Case Conferencing Tracking Sheet has a higher VI-SPDAT or Full SPDAT score OR a longer length of homelessness than the first Veteran on the By Name List, the Veteran on the Case Conferencing Tracking Sheet will be considered for a match to PSH first.
- If the first Veteran on the By Name List and the first Veteran on the Case Conferencing Tracking Sheet have the same VI-SPDAT or Full SPDAT score OR length of homelessness, the Veteran on the Case Conferencing Tracking Sheet will be considered for a match to PSH first.

However, the community team also reserves the right to consider matching a Veteran that was case conferenced without placing them on the Case Conferencing Tracking Sheet and following the process described above, if and only if:

- The Veteran being case conferenced was previously matched to a PSH resource but was unassigned
- The Veteran being case conferenced is scoring for PSH and has chronically refused housing assistance but recently became housing motivated

Matching to PSH/TAH with the Singles By Name List & Case Conferencing Tracking Sheet

As stated above, vacancies will either be filled using the Singles By Name List or the Singles Case Conferencing Tracking Sheet (see Appendix A: Glossary of Terms). Both will be sorted by the Local CAHP Prioritization Criteria for Permanent Supportive Housing (PSH), Shelter Plus Care (S+C) and Dedicated Plus Program (D+) when identifying referrals to these program types and by the Local CAHP Prioritization Criteria for Targeted Affordable Housing (TAH) when identifying referrals this program type (see Appendix B: Local CAHP Prioritization Criteria).

The community team will simultaneously review clients on the By Name List and Case Conferencing Tracking Sheet, comparing each list to identify clients with the highest VI-SPDAT or Full SPDAT score OR longest length of homelessness (depending on which sort is being applied).

The Singles CAHP Coordinator and the community team commit to upholding the following principles:

- If the first client on the By Name List has a higher VI-SPDAT or Full SPDAT score OR a longer length of homelessness than the first client on the Case Conferencing Tracking Sheet, the client on the By Name List will be considering for a match to PSH first.

- If the first client on the Case Conferencing Tracking Sheet has a higher VI-SPDAT or Full SPDAT score OR a longer length of homelessness than the first client on the By Name List, the client on the Case Conferencing Tracking Sheet will be considered for a match to PSH first.

- If the first client on the By Name List and the first client on the Case Conferencing Tracking Sheet have the same VI-SPDAT or Full SPDAT score OR length of homelessness, the client on the Case Conferencing Tracking Sheet will be considered for a match to PSH first.

Additional Housing Match Information for Veterans

Matching Veterans to PSH/TAH from the Singles By Name List

When there are not any Veteran-specific PSH resources available, Veterans that appear on the on the Singles By Name List in the I-CAHP matching meetings will be considered for a match to that resource, regardless of whether or not they are eligible for Veteran-specific PSH.

If a Veteran comes up on the Singles By Name List in the I-CAHP matching meetings and there are Veteran-specific PSH resources available, the Singles and Veterans CAHP Coordinators will verify what Veteran-specific PSH resources that client is eligible for. If they are eligible for the Veteran-specific PSH resources that are available, they will be considered for a match to those resources instead.

If during the I-CAHP matching meetings a Veteran comes up for a match, and it is unknown whether or not there are any Veteran-specific PSH resources available, this Veteran will automatically be considered for a match to the non-Veteran specific PSH/TAH resource. This will happen with the understanding that, if a Veteran-specific PSH resource becomes available within a week of this assignment being made, the Veteran can be unassigned from the non-Veteran specific PSH/TAH resource and re-assigned to the Veteran-specific PSH resource.

Matching Veterans to RRH from the Singles By Name List

When a Veteran comes up on the on the Singles By Name List in the I-CAHP matching meetings for a RRH resource, the Singles and Veteran CAHP Coordinators must determine if the Veteran is eligible for connection to SSVF. If the Veteran is SSVF eligible, they will not be matched to non-Veteran specific RRH. Instead the Singles and Veterans CAHP Coordinators will ensure they are referred to SSVF in the Veteran PSH case conferencing meetings. If the Veteran is not SSVF eligible, they will be matched to non-Veteran specific RRH. If it is unknown if the Veteran is SSVF eligible, they will be matched to non-Veteran specific RRH. The Singles and Veterans CAHP Coordinators will ensure this client is referred to the Veteran community team, who will determine eligibility. If the Veteran is found to be eligible for SSVF, the Singles and Veterans CAHP Coordinators will refer Veteran back to the Veteran Case Conferencing meetings, where they will be matched to SSVF.

Matching Veterans to TH from the Singles By Name List

Any Veterans that comes up on the on the Singles By Name List in the I-CAHP matching meetings for TH will be considered for a match to that resource, regardless of whether or not they are eligible for Veteran-specific TH.

6. HMIS Data Requirements & Expectations

Assessment, Match/Assignment and Outreach Assignment

Assessors must complete all VI-SPDAT and SPDATs in HMIS within 48 hours or two business days of when the information was first collected, whether the assessment is first conducted on paper or directly inputted within HMIS. This includes each field of the four-page VI-SPDAT assessment and both scores and comments justifying all 15 SPDAT domains.

The assigned provider or program is the specific housing program name and type for which a client was preliminarily assigned, with the understanding that further eligibility determinations may need to be made. Matches made during the I-CAHP match meetings are not guaranteed and are dependent on additional resource eligibility and documentation requirements. For example, a client may be assigned to a site-based permanent supportive housing program with a focus on chronically homeless individuals, but could later be determined not to have a disability to meet the this program requirement. The designated CAHP Coordinators or assigned housing provider must complete housing matches/referrals in HMIS within 48 hours or two business days of match. At times, additional matches beyond the number of actual program vacancies may be made as requested by the housing provider or as advised by CAHP staff.

Outreach personnel and/or point of contacts may assign themselves, or be assigned as the I-CAHP matching meetings in the HMIS.

Additional training may be required by The Community Partnership for the Prevention of Homelessness' (TCP) HMIS and CAHP personnel for the completing and monitoring assignments for clients matched to each agency and program.

Housing Placement/Move Ins, Unassignments & Re-experiences

Housing providers must record move-in date for the assigned program within 48 hours or two business days of housing placement. Placement date or move-in acknowledges that the client's physical location or sleeping location to be in the assigned program or unit. Move-in will be measured by:

(1) date of housing move-in, recorded through the "program entry" of the first VI-SPDAT assessment;
(2) exit date equal to date of move-in, and destination, recorded through the "program exit" for each VI-SPDAT assessment;
(3) through "program entry" into the permanent housing program equal to the date of "housing move-in" and "program exit" described in section 1 and 2.

Additional training may be required by The Community Partnership for the Prevention of Homelessness' (TCP) HMIS and CAHP personnel for the completing and monitoring move-in dates, unassignment and re-experience information for clients matched to each agency and program.

CAHP Data Quality Assurance Measures

The Community Partnership for the Prevention of Homelessness (TCP) oversees the implementation of the CAHP System (see Appendix A: Glossary of Terms) with designated CAHP Coordinators and Administrator. An important part of this work is the continued effort to monitor and improve data quality including, but not limited to the following:

- Monitoring assessment (VI-SPDAT and Full SPDAT) completeness and correctness;
- Outreach provider functioning and engagement information;
- Recording and monitoring assessments, assignments, move-ins, unassignments and reexperiences of homelessness;
- CAHP system reporting (placements, assessments, etc.)

On a monthly basis, the CAHP Coordinators run reports based on the VI-SPDAT Universal Registry to determine data clean-up issues related to the fields stated in the sections directly above. The success of these clean-up projects is dependent on outreach, housing and community partners and providers completion of these efforts as instructed by the CAHP Team personnel. The completion of these projects is essential to the ability of the CAHP Team to complete timely and accurate system reports.

Additional data quality efforts are dependent on the needs of the system and are subject to frequent change.

Failure to successfully execute HMIS responsibilities will require additional "refresher training" prior to re-licensure. Repeated failure of HMIS responsibilities or failure to attend refresher training will result in loss of HMIS licensure.

7. CAHP System Roles and Responsibilities

Assessors: Staff conducting the Common Assessment Tool (VI-SPDAT) must complete training which includes a review of the coordinated entry system, the VI-SPDAT tool and how to input its results within the Homeless Management Information System (HMIS). To retain HMIS licensure, all staff that have completed training must properly record its assessment results within the HMIS, including robust descriptions of the daily and weekly schedule and service utilization patterns of the individual being surveyed. If the individual being assessed possesses documentation at the time of initial assessment, the assessor must collect and copy these documents, and upload them within HMIS. Failure to fulfill these responsibilities will require an additional "refresher training" prior to re-licensure.

Attendees of I-CAHP matching meetings: Staff that attend any I-CAHP matching meetings or additional meetings in which Protected Health Class Information covered under the HIPAA-compliant Release of Information is discussed must have attended the training outlined above and have signed a User License Agreement prior to attendance.

Match Point of Contact/Assigned Outreach: Often the same staff as the Assessors, the person responsible for collecting documentation the individual currently possesses, and then obtaining remaining documentation required for housing.

Housing Providers: Responsible for reporting any housing vacancies or openings to the designated CAHP staff at the time of request, and accepting referrals from the Match Meetings according to the local prioritization criteria for permanent supportive housing, rapid rehousing and transitional housing programs. When referrals do not result in housing placement, the Housing Provider must also inform the designated CAHP staff of each instance and provide explanation prior to receiving new referrals. Additional data entry to record these instances may be required.

APPENDIX A: Glossary of Terms

1. By Name List (BNL)

a. I-CAHP By Name List:

The District of Columbia I-CAHP By Name List is the primary tool used to identify all single individuals over the age of 18 currently experiencing homelessness in the CoC, to connect individuals to services and resources, and to track assistance provided and housing outcomes for these individuals. The I-CAHP By Name List includes both Veterans and non-Veterans.

The I-CAHP By Name List is compiled on a biweekly basis and includes all single individuals in shelter and/or transitional housing (including GPD beds, VA Contract beds, and non-Veteran specific TH), all singles enrolled in SSVF or non-Veteran specific RRH, and all singles that have engaged or have been assessed by service providers, within the past 30 days.

b. Veteran By Name List:

The District of Columbia Veteran By Name List is the primary tool used to identify all single Veterans and Veteran head of households over the age of 18 currently experiencing homelessness in the CoC, connect Veterans to services and resources, and track assistance provided and housing outcomes for Veterans

The Veteran By Name List is compiled on weekly basis and includes all Veterans in shelter (including shelter for singles or families) and/or transitional housing (including GPD and VA Contract beds and non-Veteran specific TH), all Veterans enrolled in SSVF or non-Veteran specific RRH, and all Veterans that have engaged or have been assessed by service providers, within the past week.

2. Case Conferencing Tracking Sheet

a. I-CAHP Case Conferencing Tracking Sheet

The Case Conferencing Tracking Sheet includes a list of individuals that have been case conferenced, whereby the outcome was a decision to match to a resource, but no resources were available, since April 2017. This list is maintained by the Singles CAHP Coordinator and is manually updated before, during and after each I-CAHP match meeting and as otherwise needed.

b. Veteran Case Conferencing Tracking Sheet

The Case Conferencing Tracking Sheet includes a list of individuals that have been case conferenced, whereby the outcome was a decision to match to a resource, but no resources were available, since May 2017. This list is maintained by the Veterans CAHP Coordinator and is manually updated before, during and after each Veteran CAHP match meeting and as otherwise needed.

3. I-CAHP or Coordinated Assessment and Housing Placement (CAHP)

The de-centralized coordinated process whereby any individual experiencing homelessness receives Coordinated Entry into the homeless services system through a Common Assessment (the VI-SPDAT), followed by targeted assistance through Housing Match Points of Contact who obtain essential documentation for housing in order to facilitate coordinated passage, resulting in coordinated exit to permanent housing through either Permanent Supportive Housing or Rapid Rehousing.

Coordinated Entry/Coordinated Access/Coordinated Assessment: Utilized interchangeably to reflect the CAHP system.

4. I-CAHP Matching Meeting

The I-CAHP Matching Meetings are held regularly, typically twice a month, are facilitated by a CAHP Coordinator and attended by a community team comprised of assessors, service providers, outreach workers, points of contact, and housing providers. The main purpose of the match meeting is to facilitate referrals to housing programs, including but not limited to: Permanent Supportive Housing (PSH), Targeted Affordable Housing (TAH), Rapid Rehousing (RRH) and Transitional Housing (TH) resources. The I-CAHP Matching Meetings also include the process of case conferencing individuals who may need a housing resource due to extenuating circumstances that prevent them from being matched according to the By Name List and identified prioritization process. The I-CAHP Matching Meetings may also be used to match individuals to outreach team, review system gaps and correct data.

I-CAHP may at times be referred to as “Singles” CAHP.

5. HMIS or Homeless Management Information System

A Homeless Management Information System is a web-based software application designed to record and store person-level information on the characteristics and service needs of homeless persons throughout a Continuum of Care (CoC) jurisdiction. Usage of the HMIS is mandated by the U.S. Department of Housing and Urban Development (HUD) and locally by the Homeless Services Reform Act (HSRA).

6. SPDAT or Service Prioritization Decision Assistance Tool

Service Prioritization Decision Assistance Tool (VI-SPDAT) developed and owned by OrgCode is utilized for single individuals (and not families) to recommend the level of housing supports necessary to resolve the presenting crisis of homelessness. Within those recommended housing interventions, the SPDAT allows for prioritization based on presence of vulnerability across fifteen sub-components within the broader four components of the VI-SPDAT: (a) history of housing and homelessness (b) risks (c) socialization and daily functioning (d) and wellness - including chronic health conditions, substance usage, mental illness and trauma. As of the writing of this manual, there are four versions of the SPDAT: version 3 begun March 2013 and was phased out, and version 4, released May 2015 and has since been fully implemented.

7. TAY-VI-SPDAT or Next Step Tool

The Transition Aged Youth Vulnerability Index and Service Prioritization Decision Assistance Tool (TAY VI-SPDAT) developed and owned by OrgCode and Community Solutions is utilized for youth single individuals under the age of 25 (and not families) to recommend the level of housing supports necessary to resolve the presenting crisis of homelessness. Within those recommended housing interventions, the TAY-VI-SPDAT allows for prioritization based on presence of vulnerability across four components: (a)

history of housing and homelessness (b) risks (c) socialization and daily functioning (d) and wellness - including chronic health conditions, substance usage, mental illness and trauma.

8. Veteran

Locally, a Veteran is defined as anyone who has served in the US Military in any capacity or branch of service, regardless of how long they served or their discharge status. This includes individuals who did not finish basic training, who served in the military for training purposes only or were never activated, and those that served in the Reserves or National Guard.

Every client that self-reports having served in the US Military will be considered a Veteran until their service record is verified. This means that all clients that self-identify as Veterans will be included on the Singles By Name List as well as the Veterans By Name List. If confirmation is received that a client served in the US Military, they will remain on both By Name Lists.

If it is confirmed that a person who self-identifies as a Veteran has no service history, a CAHP Administrator will change the recorded Veteran status on their client profile in HMIS. Moving forward, these individuals will only be included on the Singles By Name List and they will only be considered for a match to non-Veteran specific resources.

9. VI-SPDAT

The Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) developed and owned by OrgCode and Community Solutions is utilized for single individuals (and not families) to recommend the level of housing supports necessary to resolve the presenting crisis of homelessness. Within those recommended housing interventions, the VI-SPDAT allows for prioritization based on presence of vulnerability across four components: (a) history of housing and homelessness (b) risks (c) socialization and daily functioning (d) and wellness - including chronic health conditions, substance usage, mental illness and trauma. As of the writing of this manual, there are two versions of the VI-SPDAT: version 1 begun October 2013 and was phased out. Version 2 was released in May 2015, has since been fully implemented in the District and is the only allowable version to be used by assessors.

APPENDIX B: Local CAHP Prioritization Criteria
Updated October 2018

Permanent Supportive Housing (PSH), Shelter Plus Care (S+C) and Dedicated Plus Program (D+)

Scoring Ranges: 8-17 on VI-SPDAT; 35-60 on Full SPDAT

The most general target population for PSH resources is individuals who are considered chronically homeless based on the definition provided by HUD.

PSH prioritization will be implemented with the following considerations:

- sheltered vs. unsheltered homelessness
- prioritization by service need (assessment score) and length of shelter stay/homelessness

Within those considerations, the exact prioritization of matches is as follows:

1. 70% of PSH matches will be made from the By Name List for individuals in primarily sheltered locations, prioritized by
    a. Score (weighted distribution), then
    b. Length of Shelter Stay (LoSS)
        i. LoSS will be measured by cumulative length of shelter stay in HMIS
2. 30% of PSH matches will be made from the By Name List for individuals in primarily unsheltered locations, prioritized by
    a. Score (weighted distribution), then
    b. Length of Time Homelessness
        i. LoTH will be measured by self-report on the assessment. LoTH will be confirmed by HMIS utilization; if reasonable LoTH cannot be confirmed at the time of match, the individual will not be matched to the PSH resource. An Outreach provider may submit proof of length of time homeless/chronic homelessness by writing a letter on organizations letterhead that attests to how long they can confirm the individual has been homeless.
        ii. This method will be used until we develop an official form that will document chronic homelessness and length of time homeless for all individuals.

NOTE on weighted distribution of assessment scores: matches will be taken in weighted distribution across PSH score bands

Additional Notes:

- In addition to prioritization criteria, individual program eligibility criteria may be applicable when considering individuals for housing matches.
- The one-third length of homelessness sort is not applicable to Veteran specific resources.

Targeted Affordable Housing (TAH)

The majority of TAH resources are dedicated to facilitating progressive engagement for individuals already placed in housing programs through CAHP, where a higher or lower level of service is identified. For example:

- PSH Move-on (managed directly between PSH provider and TAH administrator)
- RRH Step-Up (managed directly between RRH provider and TAH administrator)

Scoring Ranges: 4-9 on VI-SPDAT; 30-40 on Full SPDAT

For the remaining TAH resources, 80% will be targeted to those on the By Name List with recent shelter stays, and 20% will be targeted to those on the by name list who are primarily unsheltered. According to the new criteria, the individuals must be:

- chronically homeless, as documented by the criteria agreed upon by the I-CAHP workgroup
- age 60 or older
- Connected and engaged to community resources
- Scores 4-9 on VI-SPDAT **OR** 30-40 on Full-SPDAT

Within those considerations, the exact prioritization of matches is as follows:

1. 80% of TAH matches will be made from the By Name List for individuals in primarily sheltered locations, prioritized by
    a. Score (equal distribution), then
    b. Length of Shelter Stay (LoSS)
        i. LoSS will be measured by cumulative length of shelter stay in HMIS
2. 20% of TAH matches will be made from individuals who are primarily unsheltered, prioritized by
    a. Score (equal distribution), then
    b. Length of Time Homelessness
        i. LoTH will be measured by self-report on the assessment. LoTH will be confirmed by HMIS utilization; if reasonable LoTH cannot be confirmed at the time of match, the individual will not be matched to the PSH resource. An Outreach provider may submit proof of length of time homeless/chronic homelessness by writing a letter on organizations letterhead that attests to how long they can confirm the individual has been homeless.
        ii. This method will be used until we develop an official form that will document chronic homelessness and length of time homeless for all individuals.

NOTE:

- In addition to prioritization criteria, individual program eligibility criteria may be applicable when considering individuals for housing matches.
- The DC Department of Human Services (DHS) is the sole and direct funder of TAH resources.
- There are no TAH resources dedicated to the Veteran CAHP subsystem, except through the I-CAHP process and case conferencing.

Rapid Re-Housing (RRH)

Scoring Ranges: 0-3 and 4-7 on VI-SPDAT; 20-34 on Full SPDAT

Due to the number of available RRH resources and limited match meeting time, all RRH matches are made through an offline process, facilitated by the CAHP team, utilizing the By Name List and coordinating with providers.

Each RRH provider will be paired with two or more shelter locations. RRH providers and their paired shelter providers will be sent matches from the By Name List once a month (with corresponding I-CAHP match meeting dates), which will include individuals within the target population for RRH (see below), known to reside at that shelter location or otherwise referred by outreach teams.

The general target population for RRH is:

- Individuals who are able to live independently;
- Individuals under the age of 60 (informed by TAH targeting of 60+)
- Individuals with income earning potential, although income is not a formal requirement of the program

Within those considerations, the exact prioritization of matches is as follows:

1. 75% of RRH matches will be prioritized by
    a. VI-SPDAT Score (equal distribution), then
    b. Length of Shelter Stay (LoSS)
        i. LoSS will be measured by cumulative length of shelter stay in HMIS
2. 25% of RRH matches will be prioritized by
    a. Full SPDAT Score (equal distribution), then
    b. Length of Shelter Stay (LoSS)
        i. LoSS will be measured by cumulative length of shelter stay in HMIS

RRH Referrals from Outreach

Since the majority of the homeless services population is sheltered, RRH providers are formally paired with shelter locations. However, one designated RRH provider is specifically dedicated to serving individuals who are appropriate for RRH referred by outreach. These referrals are submitted via the case conferencing document typically used in the CAHP match meetings and should be emailed to the designated Singles CAHP Coordinator. Notification of referrals is made when RRH vacancies are available on a monthly basis.

NOTE:

- In addition to prioritization criteria, individual program eligibility criteria may be applicable when considering individuals for housing matches.
- The above stated RRH prioritization criteria may not be applicable for Veteran specific RRH.

Transitional Housing (TH)

Scoring Ranges: 8-12 on VI-SPDAT; 35-45 on Full SPDAT

Two-thirds of all TH matches made through CAHP will be made based on VI-SPDAT score. One-third of all TH matches made through CAHP will be made based on Full SPDAT score. Additional detail is provided below:

Assessment Score Sort Series:

- Two-thirds of the matches within this series are based upon the following order:
    - VI-SPDAT score (with an even distribution of matches made based on scores in the 8-12 range)
    - Length of homelessness (self-report, with priority given to longest lengths of homelessness)
    - Length of shelter/program stay (non-cumulative, with priority given to longest lengths of stay)
    - Overall wellness (with priority given to highest overall wellness score in the VI-SPDAT)
- One-third of the matches within this series are based upon the following order:
    - Full SPDAT score (with an even distribution of matches made based on scores in the 35-45 range)
    - Length of homelessness (self-report, with priority given to longest lengths of homelessness)
    - Length of shelter/program stay (non-cumulative, with priority given to longest lengths of stay)
    - Overall wellness (with priority given to highest overall wellness score in the VI-SPDAT)

Length of Homelessness Sort Series:

- Two-thirds of the matches within this series are based upon the following order:
    - Length of homelessness (self-report, with priority given to longest lengths of homelessness)
    - Length of shelter/program stay (non-cumulative, with priority given to longest lengths of stay)
    - VI-SPDAT score (with an even distribution of matches made based on scores in the 8-12 range)
    - Overall wellness (with priority given to highest overall wellness score in the VI-SPDAT)
- One-third of the matches within this series are based upon the following order:
    - Length of homelessness (self-report, with priority given to longest lengths of homelessness)
    - Length of shelter/program stay (non-cumulative, with priority given to longest lengths of stay)
    - Full SPDAT score (with an even distribution of matches made based on scores in the 35-45 range)
    - Overall wellness (with priority given to highest overall wellness score in the VI-SPDAT)

NOTE:

- In addition to prioritization criteria, individual program eligibility criteria may be applicable when considering individuals for housing matches.
- Anytime one of the criteria is used and there is a blank instead of a measure (such as no reported length of homelessness), the sort may be affected.

APPENDIX C: Common Assessment Tool Matrix

Name of Tool	Eligible Population	Description
VI-SPDAT	• Age 18 and older **AND** • Literally homeless (NOT couch-surfing, doubled up or unhappily housed)	Pre-screen or triage tool that looks to confirm or deny the presence of more acute issues or vulnerabilities; helps inform local prioritization criteria when resources are limited.
TAY-VI-SPDAT	• Under the age of 25 **AND** • Literally homeless and/or couch surfing, doubled up	Transition Age Youth (TAY) pre-screen or triage tool that looks to confirm or deny the presence of more acute issues or vulnerabilities; helps inform local prioritization criteria when resources are limited.
Full SPDAT	• Age 18 and older **AND** • Literally homeless and/or engaged in case management through outreach, shelter, transitional housing or permanent housing	Comprehensive assessment tool looking at the depth or nuances of an issue and the degree to which housing may be impacted. The tool, across multiple components, helps inform prioritization criteria for targeting resources. Used as an assessment of vulnerability at a moment in time and as an ongoing case management tool.

APPENDIX D: Common Assessment Tool Matrix

Recommended VI-SPDAT Assessment Script for Assessors

Opening Discussion before VI-SPDAT

This assessment helps me get to know you a little better. It asks questions about physical health, how long you've been homeless, mental health, things like that. Once I learn a little bit more about your situation, we can figure out where to start as far as helping you.

Another benefit to the assessment is that it gets your name entered into a registry of everyone who needs housing, as part of the Coordinated Entry or CAHP System. The housing providers access the registry whenever they have new openings. So by doing the assessment, you're essentially throwing your hat in the ring and making it known that you need housing.

And you only need to throw you hat in the ring once. Previously you had to go from one homeless services provider to another and tell your story over and over and over again. This assessment does away with that. Because your information gets entered into this shared registry, doing the assessment with me is the same as doing it with [the shelters, Friendship Place, Pathways, N St. Village, etc].

It's important to know from the outset, though, that there are very limited housing resources compared to all the people who need housing assistance – only 15-25% of individuals assessed have been matched to a permanent housing resource. So although this assessment makes it easier for you to access the limited housing resources that exist, it's still important to keep pursuing other things like housing opportunities outside of the Coordinated Entry system, income through employment or disability assistance, or meeting your health care needs.

One important part is the release of information. By signing this release, you're giving me permission to enter your assessment into a shared registry. Your information is shared with anyone who has access to the registry and also does these assessments. It's not shared with random people, like the guy walking down the street, but it is shared with some homeless service providers and housing providers in DC -- people who might be in a position to help you.

Post VI-SPDAT Discussion

PSH Recommendation

So what the assessment tells me is that Permanent Supportive Housing is the type of housing that makes the most sense for you. What that means is that you have a lot going on in your life. You revealed in the assessment that: [*choose the most appropriate option(s)*: you have mental health concerns, you have medical issues, you're dealing with some alcohol/drug use, you've been homeless for x years, etc]. That means that Permanent Supportive Housing is likely the best fit. It comes with funding that helps pay the rent, and it also comes with a

case manager who checks in from time to time to make sure everything's going ok. For example, the case manager helps interface with the landlord, makes sure the rent is getting paid, makes sure that maintenance comes out and fixes your toilet if your toilet breaks, that kind of thing.

The good news is that we know this now, so you can focus your housing search on Permanent Supportive Housing programs. ([*if applicable*] Also, the DC government is starting to dedicate more funding to Permanent Supportive Housing programs.) The bad news is that a lot of people need Permanent Supportive Housing, like a lot of the people [*choose the most appropriate option:* here in the shelter, here in the dining room, out on the streets, etc]. I wish there was more funding, and homeless service providers are working on getting more funding, but I don't have an immediate answer right now. The best thing you can do is be present: check in with me, check in with [shelter, meals program, etc], reach out to me if your contact information changes. It's the worst when someone has an opportunity for a housing but we can't get in touch with them and they end up losing that opportunity. You and I can also start tackling some other stuff in the meantime. I can [*choose the most appropriate option(s)*: explore housing opportunities outside of Coordinated Entry (like affordable housing buildings or shared housing), get you hooked up with a doctor, call the Access Helpline and get you mental health services, help you with your resume, help you get your ID docs, etc].

RRH Recommendation

So what the assessment tells me is that Rapid Rehousing is the type of housing that likely makes the most sense for you. You shared in the assessment that you have some concerns, like [*choose the most appropriate option(s)*: mental health concerns, medical issues, some alcohol/drug use, you've been homeless for x years, etc]. But you're otherwise pretty independent and you don't need a case manager checking in on you every day. You basically need a leg up, but you otherwise have things pretty well managed. Rapid Rehousing provides short-term rental assistance and case management. That's the leg up that will help you find an apartment and get off the streets/out of the shelters. The good news is that DC has a Rapid Rehousing program, and by doing this assessment, you're considered eligible for it. The bad news is that a lot of people need Rapid Rehousing, like a lot of the people [*choose the most appropriate option*: here in the shelter, here in the dining room, out on the streets, etc]. I wish there was more funding, and homeless service providers are working on getting more funding, but I don't have an immediate answer right now. The best thing you can do is be present: check in with me, check in with [shelter, meals program, etc.], reach out to me if your contact information changes. It's the worst when someone has an opportunity for Rapid Rehousing but we can't get in touch with them and they end up losing that opportunity. You and I can also start tackling some other stuff in the meantime. I can [*choose the most appropriate option(s)*: explore housing opportunities outside of Coordinated Entry (like affordable housing buildings or shared housing), get you hooked up with a doctor, call the Access Helpline and get you mental health services, help you with your resume, etc].

One-time Assistance Recommendation

What the assessment tells me is that you're pretty self-sufficient and independent. Something like a security deposit might be helpful, but otherwise you don't need to have a case manager checking on you all the time or anything like that. With people in your situation, I've found it's helpful to [*choose the most appropriate option(s)*: work on getting steady employment, seek out ERAP, reconnect with family, explore housing opportunities outside of Coordinated Entry(like affordable housing buildings or shared housing), etc].